

Whole Child Assessment- Version 3 for 2 – 3 Years

Please answer all the questions on this form as best you can. It will help us know how we can help your child be healthy. **You may skip any question if you do not know an answer or do not want to answer.** You may add comments to explain your answers. We will keep this information confidential, unless there is concern that your child is being hurt.

1	Person completing form	☐ Biological Parent(s) ☐ Step Parent(s) ☐ Adopted Parent(s) ☐ Foster Parent(s) ☐ Friend(s) ☐ Other (<i>specify</i>)			
2	Does your child go to daycare or preschool?	Yes	Unsure	No	1 Interval History
3	Since the last visit, has your child				
	• Been seen in another clinic?	No	Unsure	Yes	
	• Developed a new illness?	No	Unsure	Yes	
	• Been seen in the Emergency Room?	No	Unsure	Yes	
	• Been hospitalized?	No	Unsure	Yes	
	• Had an operation?	No	Unsure	Yes	
4	Since the last visit, have there been any changes or events that were stressful, scary, or upsetting to your child?	No	Unsure	Yes	
5	Do you have any questions or concerns about your child's growth, development, or behavior? <i>If yes, please describe:</i>	No	Unsure	Yes	
6	Has a family member or close contact had tuberculosis disease during your child's lifetime?	No	Unsure	Yes	10 Tuberculosis
7	Was your child born in the United States?	Yes	Unsure	No	
8	Has your child lived or traveled outside of the United States for at least a month ?	No	Unsure	Yes	
9	Do you help your child brush her/his teeth twice daily?	Often	Sometimes	Never	9 Dental
10	In the past year, has your child been seen twice by a dentist?	Yes	Unsure	No	
11	How many servings of fruit OR vegetables (about the size of your child's fist) does your child eat each day ?	5+	2-4	0-1	8 Nutrition
12	How many servings a day does your child drink or eat of calcium-rich foods, such as milk, cheese, yogurt, soy milk, OR tofu?	3+	2	0-1	
13	How many times a day does your child drink a cup (about 8 oz) of juice, soda, sports drinks, energy drinks, OR other sweetened drinks?	0-1	2	3+	
14	How many times a week does your child eat breakfast?	6-7	3-5	0-2	
15	How many times a week does your child eat high-fat foods, such as fried foods, pizza, OR other fast food?	0-1	2-3	4+	
16	Is your child enrolled in WIC?	Yes	Unsure	No	

Whole Child Assessment- Version 3 for 2 – 3 Years

17	Does your child play actively for at least 1 hour each day?	Yes	Unsure		No	7 Physical Activity	
18	How many hours a day does your child spend on screen time (TV, phone, computer, tablet, video games, etc.)?	0-1	2+ Sometimes		2+ Often		
19	Does your child have trouble falling asleep or staying asleep?	Never	Sometimes		Often	6 Sleep	
20	Do you feel your child is difficult to take care of?	Never	Sometimes		Often	5 Relationships	
21	Do you find you need to shout or yell at your child?	Never	Sometimes		Often		
22	Do you find you need to hit or spank your child?	Never	Sometimes		Often		
23	Are your child's parents separated, divorced, or not living together?	No	Deceased parent	Unsure	Yes		
24	Does your family look out for each other, feel close to each another, and support each other?	Often	Sometimes		Never		
25	Did a parent or household member get arrested, deported, go to prison, jail, or other correctional facility during your child's lifetime?	No	Unsure		Yes		
26	Do you know or are you concerned that anyone touched your child, or forced your child to touch that person, in a sexual way?	No	Unsure		Yes		
27	Is your child fussy or irritable?	Never	Sometimes		Often	4 Mental Health	
28	Was a parent or household member ever depressed, mentally ill, OR suicidal?	No	Unsure		Yes		
29	How about you— Over the past 2 weeks , how often have you been bothered by any of the following problems? A1. Little interest or pleasure in doing things A2. Feeling down, depressed, or hopeless B1. Feeling nervous, anxious, or on edge B2. Not being able to stop or control worrying	Not at all 0 0 0 0	Several days 1 1 1 1	More than half the days 2 2 2 2	Nearly every day 3 3 3 3		A: B:
30	Does your child spend time with anyone who smokes, vapes, OR uses e-cigarettes?	No	Unsure		Yes		3 Substances
31	In the past year, how many times have you had 4 or more drinks containing alcohol in one day ?	0	1		2+		
32	Did a parent or household member ever have a problem with drugs OR alcohol?	No	Unsure		Yes		
33	Does your home have a working smoke detector and carbon monoxide detector?	Yes	Unsure		No	2 Safety	
34	Does your home have cleaning supplies, medicines, and matches locked away?	Yes	Unsure		No		
35	Do you always stay with your child when she/he is in the bathtub?	Yes	Unsure		No		
36	Do you always place your child in a car seat in the back seat?	Yes	Unsure		No		
37	Does your child always wear a helmet when on a bike, skateboard, scooter, or roller blades?	Yes	Does not ride		No		
38	Does your child spend time near a swimming pool, river, lake, or hot tub?	No	Unsure		Yes		
39	Does your child spend time in a home where a gun is kept?	No	Unsure		Yes		

Whole Child Assessment- Version 3 for 2 – 3 Years

40	Has your child ever seen or heard adults in the home pushing, hitting, kicking, OR physically threatening each other?	No	Unsure	Yes	2 Safety		
41	Has your child ever lived with a parent or other adult who physically hurt the child in anger?	No	Unsure	Yes			
42	On average, how difficult was it for your family to meet expenses for basic needs like food, clothing, and housing in the last year ?	Not at all	A little	Somewhat		Fairly	Very
43	Would you like someone to follow-up with you about community resources?	No	Unsure	Yes			

If you have additional concerns, comments, or questions, please describe here:

<i>Clinic Use Only:</i> circle each question with a positive response, sum number of circled questions											
Child-ACE Exposures:	21	23	24	25	26	28	32	40	41	42	Σ =
Child-ACE Risks:	1	20	22	29A	29B	31					Σ =
Child-ACE Total											Σ =
PCP's Signature				Print Name						Date	